# APPLICATION FOR CHIROPRACTIC LICENSE

State Form 5174 (R6 / 4-01)
Approved by State Board of Accounts, 2001

**HEALTH PROFESSIONS BUREAU**
402 West Washington Street, Room 041
Indianapolis, Indiana 46204
(317) 232-2960
http://www.state.in.us/hpb

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

| | |
|---|---|
| **APPLICATION FEE** | |
| **DATE FEE PAID** | |
| **RECEIPT NUMBER** | |
| **LICENSE NUMBER** | |
| **LICENSE ISSUANCE DATE** | |

**APPLICANT**

Attach one (1) passport-quality photograph taken not earlier than one (1) year prior to the date of application.

**DO NOT WRITE ABOVE THIS LINE - FOR OFFICE USE ONLY**

## APPLICANT INFORMATION

| Name of applicant (*last, first, middle, maiden*) | Social Security number* | |
|---|---|---|
| Address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Date of birth | Place of birth (*city and state or country*) | |
| Telephone number (*daytime*) | E-mail address | |

## BASIS FOR LICENSURE

Application for licensure by: (*Please check appropriate box.*)

☐ EXAMINATION ☐ ENDORSEMENT

If applying by examination, what date will you be taking or have taken the National Board of Chiropractic Examiners - Part IV examination? **Date of examination**

## TEMPORARY PERMIT

**(***EXAMINATION CANDIDATE'S ONLY - TAKING THE NBCE - PART IV EXAMINATION FOR THE FIRST TIME***)**

Do you wish to apply for a temporary permit?

☐ Yes ☐ No

## CHIROPRACTIC SCHOOL OF GRADUATION

| NAME OF SCHOOL | LOCATION | DATE OF GRADUATION |
|---|---|---|
| | | |

## EXAMINATION RECORD

**NATIONAL BOARD OF CHIROPRACTIC EXAMINERS**

| NATIONAL BOARDS | Date of most recent test (*month, day, year*) | WHERE TAKEN (*State*) | HOW MANY TIMES? |
|---|---|---|---|
| **PART I** | | | |
| **PART II** | | | |
| **PART III** | | | |
| **PART IV** | | | |
| **PHYSIOTHERAPY** | | | |

Have you ever failed Part IV? (*If Yes, please state the date and location.*)

☐ Yes ☐ No

## EXAMINATION RECORD (*con't.*)

### STATE BOARD EXAMINATION

If you are applying by endorsement, please list the State Board Examination you will be endorsing to the State of Indiana.

| STATE | EXAMINATION DATE | LICENSE CURRENT? |
|---|---|---|
| | | ☐ Yes ☐ No |

### PRE-PROFESSIONAL EDUCATION

| NAME OF SCHOOL | LOCATION | FROM MONTH/YEAR | TO MONTH/YEAR | DEGREE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### PROFESSIONAL EDUCATION (SCHOOL OF CHIROPRACTIC)

| NAME OF SCHOOL | LOCATION | FROM MONTH/YEAR | TO MONTH/YEAR | DEGREE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| Original state of licensure | License number |
|---|---|
| | |

### LIST ALL STATES INCLUDING INDIANA IN WHICH YOU HAVE BEEN LICENSED TO PRACTICE CHIROPRACTIC

| STATE | LICENSE NUMBER | DATE ISSUED | DATE EXPIRES | ISSUED BY EXAMINATION OR ENDORSEMENT? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

### LICENSED FOR THREE YEARS

If you are applying by endorsement, please list the states where you have been licensed for three (3) years under qualifications substantially equivalent to Indiana

| STATE | LICENSE NUMBER | DATE ISSUED | DATE EXPIRES |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### LIST ALL PLACES YOU HAVE LIVED SINCE GRADUATION FROM CHIROPRACTIC SCHOOL

| GENERAL LOCATION | DATE |
|---|---|
| | |
| | |
| | |
| | |

| LIST ALL PLACES OF EMPLOYMENT SINCE GRADUATION FROM CHIROPRACTIC SCHOOL | | |
|---|---|---|
| **NAME AND ADDRESS OF EMPLOYER** | **RESPONSIBILITIES** | **DATES OF EMPLOYMENT** |
| | | |
| | | |
| | | |

| **If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. If malpractice, provide name(s) of plantiff(s). Letter from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license or permit issued pursuant to this application.** | |
|---|---|
| 1. Have you ever previously filed an application in the State of Indiana? | ☐ Yes ☐ No |
| 2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? | ☐ Yes ☐ No |
| 3. Have you ever been denied a license, certificate, registration or permit to practice chiropractic or any regulated health occupation in any state (*including Indiana*) or country? | ☐ Yes ☐ No |
| 4. Are you now being, or have you ever been, treated for a drug abuse or alcohol problem? | ☐ Yes ☐ No |
| 5. Have you ever been convicted of, plead guilty or nolo contendere to:<br>A. A violation of any Federal, State, or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction.<br>B. Any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines.*) | ☐ Yes ☐ No<br>☐ Yes ☐ No |
| 6. Have you ever had a malpractice judgement against you or settled any malpractice action? | ☐ Yes ☐ No |

| **APPLICATION AFFIRMATION** | |
|---|---|
| I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct. | |
| Signature of applicant | Date signed (*month, day, year*) |

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize, request and direct any person, firm, officer, corporation , association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for chiropractic licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application, and I hereby specifically release the Bureau and Board from any and all liability in connection with such disclosure.

A photostatic copy of the authorization has the same force and effect as the original.

| **AFFIRMATION** | |
|---|---|
| I hereby swear or affirm that I have read the above statements and agree to same. | |
| Signature of applicant | Date signed (*month, day, year*) |

# APPLICATION FOR CHIROPRACTIC TEMPORARY PERMIT (Examination Candidates Only)

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http://www.state.in.us/hpb

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| FOR OFFICE USE ONLY | |
|---|---|
| **TEMPORARY PERMIT FEE** | |
| **DATE FEE PAID** | |
| **RECEIPT NUMBER** | |
| **TEMPORARY PERMIT NUMBER** | |
| **DATE ISSUED** | |

**THIS SECTION TO BE COMPLETED BY THE APPLICANT**

| Name of applicant (*last, first, middle, maiden*) | | Social Security number* | |
|---|---|---|---|
| Address (*number and street or rural route*) | | | |
| City | | State | ZIP code |
| Telephone number (*daytime*) | | Date of birth | |
| School of graduation | | Date of graduation | |
| What date will you be sitting for the National Board of Chiropractic Examiners - Part IV Examination? | | Have you ever failed the National Boards - Part IV Examination? ☐ Yes ☐ No | |

**I understand that as a holder of a temporary permit I may not provide an independent diagnosis of a patient.**

| Signature of applicant | Date signed |
|---|---|

**THIS SECTION TO BE COMPLETED BY THE SUPERVISING CHIROPRACTOR**

| Name of supervisor | | Social Security number* | |
|---|---|---|---|
| Address (*number and street, or rural route*) | | | |
| City | | State | ZIP code |
| Telephone number ( ) | Indiana license number | Expiration date of license | |

**PRACTICE LOCATION**

| Name of practice | | | |
|---|---|---|---|
| Address (*number and street or rural route*) | | | |
| City | State | ZIP code | Telephone number ( ) |

**I will be exclusively responsible for the direct supervision of the chiropractic graduate who is applying for this temporary permit.**

| Signature of supervisor | Date signed |
|---|---|

# VERIFICATION OF CHIROPRACTIC STATE LICENSURE

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Type and complete the top section. Make copies to send to each state you hold or have held a license. Request the state(s) to complete and send directly to:

Health Professions Bureau
402 W. Washington Street
Room 041
Indianapolis, IN 46204
(317) 232-2960

**PLEASE TYPE OR PRINT**

| Name of applicant | Social Security number* |
|---|---|
| | |

Address (*number and street, or rural route*)

City, state, ZIP code

| Date of birth (*month, day, year*) | License number | Date of issue |
|---|---|---|
| | | |

I hereby authorize the State of _____ to furnish the Health Professions Bureau of Indiana with the information below.

| Signature of applicant | Date signed |
|---|---|
| | |

| License number | Date of issuance (*month, day, year*) | Expiration date (*month, day, year*) |
|---|---|---|
| | | |

**Has the license been subject to disciplinary action? (***Please attach copies of any disciplinary action taken by your board.***)**
☐ Yes ☐ No

**LICENSED BY:**

☐ Examination ☐ Endorsement ☐ Other

☐ National Boards ☐ Part I ☐ Part II ☐ Part III (WCCE) ☐ Part IV ☐ Physiotherapy

| State examination administered? | Date of examination (*month, day, year*) |
|---|---|
| ☐ Yes ☐ No | |

**STATE EXAMINATION SUBJECTS AND SCORES**

| AREA | ORAL / PRACTICAL | APPLICANT'S SCORE | PASSING SCORE |
|---|---|---|---|
| **Chiropractic Technique** | ☐ Yes ☐ No | | |
| **Orthopedic Testing** | ☐ Yes ☐ No | | |
| **Neurological Testing** | ☐ Yes ☐ No | | |
| **Physical Diagnosis** | ☐ Yes ☐ No | | |
| **X-Ray Interpretation** | ☐ Yes ☐ No | | |
| **Case Management** | ☐ Yes ☐ No | | |

| Name | **Please Affix Board Seal** |
|---|---|
| Title | |
| State Board | |
| Date | |